

		FOR BHF USE				

LL1

**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0047209</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																
<b>Facility Name:</b> <u>East Bank Center LLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>6/15/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																
<b>Address:</b> <u>6131 Park Ridge Rd</u> <u>Loves Park</u> <u>61111</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																
<b>County:</b> <u>Winnebago</u>																		
<b>Telephone Number:</b> <u>(815) 633-6810</u> <b>Fax #</b> <u>(815) 633-5095</u>																		
<b>HFS ID Number:</b> <u>202575113-001</u>																		
<b>Date of Initial License for Current Owners:</b> <u>6/15/2005</u>																		
<b>Type of Ownership:</b>																		
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		<input checked="" type="checkbox"/> PROPRIETARY																
<input type="checkbox"/> Charitable Corp.		<input type="checkbox"/> Individual																
<input type="checkbox"/> Trust		<input type="checkbox"/> State																
<b>IRS Exemption Code</b> _____		<input type="checkbox"/> Partnership																
		<input type="checkbox"/> Corporation																
		<input type="checkbox"/> "Sub-S" Corp.																
		<input checked="" type="checkbox"/> Limited Liability Co.																
		<input type="checkbox"/> Trust																
		<input type="checkbox"/> Other _____																
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Edna L. Lopez</u> <b>Telephone Number:</b> <u>(815) 633-6810</u>		<table border="1"> <tr> <td rowspan="2"> <b>Officer or Administrator of Provider</b> </td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) <u>6/9/2006</u></td> </tr> <tr> <td rowspan="5"> <b>Paid Preparer</b> </td> <td>(Type or Print Name) <u>Edna L. Lopez</u></td> </tr> <tr> <td>(Title) <u>Administrator</u></td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Date) <u>6/9/2006</u></td> </tr> <tr> <td>(Print Name and Title) <u>David Lindgren Accountant</u></td> </tr> <tr> <td colspan="2">           (Firm Name &amp; Address) <u>Lindgren &amp; Callahan 61125 4949 Harrison Ave., Suite 300, P.O. Box 5407, Rockford, IL.</u> </td> </tr> <tr> <td colspan="2">           (Telephone) <u>(815) 399-7700</u> Fax # <u>(815) 399-7644</u> </td> </tr> <tr> <td colspan="2">           MAIL TO: BUREAU OF HEALTH FINANCE            ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES            201 S. Grand Avenue East            Springfield, IL 62763-0001 Phone # (217) 782-1630         </td> </tr> </table>		<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) <u>6/9/2006</u>	<b>Paid Preparer</b>	(Type or Print Name) <u>Edna L. Lopez</u>	(Title) <u>Administrator</u>	(Signed) _____	(Date) <u>6/9/2006</u>	(Print Name and Title) <u>David Lindgren Accountant</u>	(Firm Name & Address) <u>Lindgren &amp; Callahan 61125 4949 Harrison Ave., Suite 300, P.O. Box 5407, Rockford, IL.</u>		(Telephone) <u>(815) 399-7700</u> Fax # <u>(815) 399-7644</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<b>Officer or Administrator of Provider</b>	(Signed) _____																	
	(Date) <u>6/9/2006</u>																	
<b>Paid Preparer</b>	(Type or Print Name) <u>Edna L. Lopez</u>																	
	(Title) <u>Administrator</u>																	
	(Signed) _____																	
	(Date) <u>6/9/2006</u>																	
	(Print Name and Title) <u>David Lindgren Accountant</u>																	
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## STATE OF ILLINOIS

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Facility Name & ID Number East Bank Center, LLC# 0047209 Report Period Beginning: 6/15/2005 Ending: 12/31/2005

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds54

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>54</u>	Skilled (SNF)	<u>54</u>	<u>1,437</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>54</u>	TOTALS	<u>54</u>	<u>1,437</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,628</u>	<u>410</u>	<u>14</u>	<u>4,052</u>	8
9	SNF/PED	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	9
10	ICF	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	10
11	ICF/DD	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	12
13	DD 16 OR LESS	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	13
14	TOTALS	<u>3,628</u>	<u>410</u>	<u>14</u>	<u>4,052</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 2.82%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 6/15/2005

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 6/15/2005NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 54and days of care provided 1,437Medicare Intermediary Administar

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2005 Fiscal Year: 12/31/05

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number East Bank Center LLC

# 0047209

Report Period Beginning: 6/15/2005

Ending: 12/31/2005

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	66,373	7,600	383	74,356		74,356		74,356			1
2	Food Purchase		43,826		43,826		43,826		43,826			2
3	Housekeeping	44,157	6,295	143	50,595		50,595		50,595			3
4	Laundry		5,802		5,802		5,802		5,802			4
5	Heat and Other Utilities			26,014	26,014		26,014		26,014			5
6	Maintenance	36,039	5,826		41,865		41,865		41,865			6
7	Other (specify):* Water Removal			3,862	3,862		3,862		3,862			7
8	<b>TOTAL General Services</b>	146,569	69,349	30,402	246,320		246,320		246,320			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			3,500	3,500		3,500		3,500			9
10	Nursing and Medical Records	340,616	60,580	1,612	402,808		402,808		402,808			10
10a	Therapy			73,067	73,067		73,067		73,067			10a
11	Activities	24,496	1,288	120	25,904		25,904		25,904			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	365,112	61,868	78,299	505,279		505,279		505,279			16
	<b>C. General Administration</b>											
17	Administrative	47,077			47,077		47,077		47,077			17
18	Directors Fees											18
19	Professional Services			250	250		250		250			19
20	Dues, Fees, Subscriptions & Promotions			935	935		935		935			20
21	Clerical & General Office Expenses	40,883	11,009	17,735	69,627		69,627	(7,497)	62,130			21
22	Employee Benefits & Payroll Taxes			113,651	113,651		113,651		113,651			22
23	Inservice Training & Education											23
24	Travel and Seminar			390	390		390		390			24
25	Other Admin. Staff Transportation			533	533		533		533			25
26	Insurance-Prop.Liab.Malpractice			46,233	46,233		46,233		46,233			26
27	Other (specify):*	47,565		15,419	62,984		62,984	(55,626)	7,358			27
28	<b>TOTAL General Administration</b>	135,525	11,009	195,146	341,680		341,680	(63,123)	278,557			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	647,206	142,226	303,847	1,093,279		1,093,279	(63,123)	1,030,156			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number East Bank Center LLC

#0047209

Report Period Beginning: 6/15/2005 Ending: 12/31/2005

12/31/2005

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			69,878	69,878		69,878		69,878			30
31	Amortization of Pre-Op. & Org.			3,425	3,425		3,425		3,425			31
32	Interest			75,944	75,944		75,944	(2,706)	73,238			32
33	Real Estate Taxes			11,816	11,816		11,816		11,816			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			39,401	39,401		39,401		39,401			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			200,464	200,464		200,464	(2,706)	197,758			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			11,712	11,712		11,712		11,712			38
39	Ancillary Service Centers			37,002	37,002		37,002		37,002			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			15,137	15,137		15,137		15,137			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			63,851	63,851		63,851		63,851			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	647,206	142,226	568,162	1,357,594		1,357,594	(65,829)	1,291,765			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,497)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(2,706)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(220)	27		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5)	27		24
25	Fund Raising, Advertising and Promotional	(55,401)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,829)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (65,829)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$ 11,712	38	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs			37,002	39	43
44	Exceptional Care Program					44
45	Other-Attach Schedule			15,137	42	45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 63,851		47

East Bank Center LLC

ID# 0047209

Report Period Beginning: 6/15/2005

Ending: 12/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

12/31/2005

[illegible]

## Summary B

12/31/2005

[illegible]

Facility Name &amp; ID Number East Bank Center LLC

# 0047209

Report Period Beginning:

6/15/2005

Ending:

12/31/2005

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Following						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number East Bank Center LLC

#

0047209Report Period Beginning: 6/15/2005 Ending: 12/31/2005

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number East Bank Center LLC# 0047209 Report Period Beginning: 6/15/2005 Ending: 2/31/2005

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number East Bank Center LLC# 0047209

Report Period Beginning:

6/15/2005

Ending:

12/31/2005**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Choice Bank 71545		x	Mortgage	(A)	6/17/2005	\$ 1,230,000	\$ 1,230,000	6/17/2025	0.8250	\$ 66,587	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6			x	Operating LOC	(B)	6/21/2005	300,000	286,290	6/21/2007	0.8250	6,651	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,530,000	\$ 1,516,290			\$ 73,238	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,530,000	\$ 1,516,290			\$ 73,238	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name &amp; ID Number East Bank Center LLC

# 0047209

Report Period Beginning:

6/15/2005

Ending:

12/31/2005

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 11,816	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 11,816	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	8		
	2001	9		
	2002	10		
	2003	11		
	2004	12	21,027	

Accrual is based on a 5% increase over prior year bill. \$21,027 x 1.05 = \$22,000 less credit at closing of property purchase.

		<b>FOR OHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2004	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME East Bank Center LLC COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0047209

CONTACT PERSON REGARDING THIS REPORT James Palazzo

TELEPHONE (815) 633-6810 FAX #: (815) 633-5095

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-01-252-012</u>	<u>Facility</u>	\$ <u>20,187.00</u>	\$ <u>20,187.00</u>
2. <u>11-01-177-016</u>	<u>Land</u>	\$ <u>840.00</u>	\$ <u>840.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>21,027.00</u>	\$ <u>21,027.00</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? \_\_\_\_\_ YES    x \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005

A. Square Feet:

15,000

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

2

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

88,066

2. Number of Years Over Which it is Being Amortized:

15 years

3. Current Period Amortization:

3,425

4. Dates Incurred:

6/15/2005

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Rehab Facility	15,000	2005	\$ 50,000	1
2					2
3	TOTALS	15,000		\$ 50,000	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		2005		\$ 844,430	\$ 12,630	39	\$ 12,630		\$ 12,630	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building remodeling (not in service at 12/31/05)			2005	143,643		39				9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 988,073	\$ 12,630		\$ 12,630	\$	\$ 12,630	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	745,277	57,248	57,248		Various	57,248	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 745,277	\$ 57,248	\$ 57,248	\$		\$ 57,248	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,783,350	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,878	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,878	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 69,878	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

\*\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2006 \$ \_\_\_\_\_

13. \_\_\_\_\_/2007 \$ \_\_\_\_\_

14. \_\_\_\_\_/2008 \$ \_\_\_\_\_

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM** (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b>  <div style="display: flex; justify-content: space-between;"> <span><input type="checkbox"/> YES</span> <span><input checked="" type="checkbox"/> NO</span> </div> <p style="font-size: small;">If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER CNA _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER CNA _____
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ None

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3	4	5		6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-3	176 # of prescripts	37,002				176	37,002		9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$ 37,002		\$	\$	176	\$ 37,002		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (193)	\$	1
2	Cash-Patient Deposits	477		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	340,298		3
4	Supply Inventory (priced at Cost )	16,230		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,033		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Advance	100		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 363,945	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	988,073		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	745,277		16
17	Accumulated Depreciation (book methods)	(69,878)		17
18	Deferred Charges	246,875		18
19	Organization & Pre-Operating Costs	88,066		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,425)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	24,350		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,069,338	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,433,283	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 656,647	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,377		28
29	Short-Term Notes Payable	286,290		29
30	Accrued Salaries Payable	56,917		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36		7,452		36
37		7,243		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,038,926	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,230,000		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,230,000	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,268,926	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 164,357	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,433,283	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(435,643)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Members Capital Contributed	600,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 164,357	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 164,357	24 *

\* This must agree with page 17, line 47.

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number East Bank Center LLC

# 0047209

Report Period Beginning: 6/15/2005

Ending:

12/31/2005

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 921,951	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 921,951	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 921,951	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	246,320	31
32	Health Care	505,279	32
33	General Administration	341,680	33
	<b>B. Capital Expense</b>		
34	Ownership	200,464	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	63,851	35
36	Provider Participation Fee		36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,357,594	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(435,643)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (435,643)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number East Bank Center LLC

# 0047209

Report Period Beginning: 6/15/2005

Ending:

12/31/2005

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	712	712	\$ 26,308	\$ 36.95	1
2	Assistant Director of Nursing	872	872	38,500	44.15	2
3	Registered Nurses	2,602	2,602	98,589	37.89	3
4	Licensed Practical Nurses	2,679	2,679	65,405	24.41	4
5	CNAs & Orderlies	8,163	8,163	98,606	12.08	5
6	CNA Trainees					6
7	Licensed Therapist	583	583	22,718	38.97	7
8	Rehab/Therapy Aides					8
9	Activity Director	872	872	18,615	21.35	9
10	Activity Assistants	831	831	8,426	10.14	10
11	Social Service Workers	410	410	6,195	15.11	11
12	Dietician	160	160	5,412	33.83	12
13	Food Service Supervisor	913	913	22,952	25.14	13
14	Head Cook	1,478	1,478	15,968	10.80	14
15	Cook Helpers/Assistants	1,493	1,493	14,648	9.81	15
16	Dishwashers					16
17	Maintenance Workers	1,264	1,264	32,923	26.05	17
18	Housekeepers	4,117	4,117	41,811	10.16	18
19	Laundry					19
20	Administrator	872	872	44,000	50.46	20
21	Assistant Administrator	878	878	34,879	39.73	21
22	Other Administrative					22
23	Office Manager	376	376	3,196	8.50	23
24	Clerical	100	100	1,090	10.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	48	48	6,000	125.00	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	504	504	16,233	32.21	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	798	798	24,732	30.99	33
34	TOTAL (lines 1 - 33)	30,725	30,725	\$ 647,206 *	\$ 21.06	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	40	3,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	16	70,504	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	56	\$ 74,004		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
James M. Palazzo	Administrator	0	\$ 47,077	Workers' Compensation Insurance		\$ 21,703	IDPH License Fee		\$		
				Unemployment Compensation Insurance		26,546	Advertising: Employee Recruitment				
				FICA Taxes		46,247	Health Care Worker Background Check (Indicate # of checks performed _____)				
				Employee Health Insurance		15,294	RKFD Chamber Dues		515		
				Employee Meals			Minorities & Success		395		
				Illinois Municipal Retirement Fund (IMRF)*			The Ladders		25		
				Dental Insurance		1,317					
				Other Employee Costs		3,861					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)											
\$ 47,077											
B. Administrative - Other											
Description			Amount								
			\$								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$								
C. Professional Services											
Vendor/Payee	Type		Amount	Description		Line #	Amount				
Sharon Haugh	Billing Consultant		\$ 250								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)											
\$ 250											
D. Employee Benefits and Payroll Taxes						E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
TOTAL (agree to Schedule V, line 22, col.8)						\$ 114,968					

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number East Bank Center LLC

STATE OF ILLINOIS

# 0047209

Report Period Beginning: 6/15/2005

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Ending: 12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,200 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? N/A If NO, attach a complete explanation. \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 15,137  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. \_\_\_\_\_
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0%  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.